Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 10, No.2 Summer 2002

Reported Lyme Disease Cases More Than Double In Western Massachusetts

The combined reported incidence of Lyme disease in Berkshire, Franklin, Hampden and Hampshire Counties more than doubled between 1998 and 2000, from 8.5 cases per 100,000 people in 1998 to 20.2 cases per 100,000 in 2000. The reported incidence of Lyme disease in Massachusetts in 2000 was 18.1 cases per 100,000, nationally the rate is 6.3 cases per 100,000. Lyme disease is an even larger problem for Massachusetts than was previously recognized. The new data underscore the need to get prevention messages to residents about protecting themselves and to healthcare providers about how to recognize the symptoms of Lyme disease.

The only way to become infected with Lyme disease is through the bite of an infected deer tick. Ticks live not only in the woods and near sandy dunes, but in yards and parks as well. Everyone should protect themselves from tick bites, using the following measures:

- The single most important thing is to check yourself for ticks once a day.
- Remove any attached tick you find as soon as possible. Ticks must usually be attached for at least 24 hours to transmit the infection.
- Wear long-sleeved light colored shirts and long pants tucked into socks.
- Consider using a tick repellent with no more than 30-35% DEET (10-15% for children). **Follow product instructions carefully. Do not use insect repellents on infants.**

If you develop an enlarging red rash, especially if it begins to look like an expanding ring and if the rash is associated with fever, muscle aches or other symptoms, contact a health care provider and get checked for early Lyme disease. In it's earliest stages Lyme disease can be cured by antibiotics and complications can be prevented.

There are several ways to reduce the number of ticks in your yard. For more information, contact your local board of health or visit the Massachusetts Department of Public Health website at www.state.ma.us/dph.

Acquired Rifamycin Resistance in Persons with AIDS and Active Tuberculosis

The Centers for Disease Control and Prevention (CDC) published a notice urging caution when prescribing rifamycins (i.e., rifampin, rifapentine, or rifabutin) for patients with AIDS and active tuberculosis (MMWR 51:214-215, 2002). This action was prompted by the discovery in 5 isolates of *Mycobacterium tuberculosis* with acquired rifamycin resistance among patients enrolled in CDC's TB Trials Consortium Study 23, a study of twice-weekly rifabutin-based treatment for patients with AIDS and tuberculosis, and by data from earlier clinical studies. The mechanism(s) responsible for this phenomenon is (are) not known.

Until additional data are analyzed, CDC recommends the following:

• For persons with HIV infection and TB and CD4 counts <100/mm^3 at the time of TB diagnosis: once- or twice-weekly anti-tuberculosis regimens should not be used; rather, daily therapy should be administered during the intensive phase, followed by daily or 3 times-a-week treatment during continuation phase. Directly observed therapy should be used throughout, with direct observation of treatment administration by a health care provider during both daily and intermittent treatment phases. Current CDC guidelines regarding length of treatment should be followed.

• In patients with advanced AIDS and TB treated with twice- or once-weekly regimens containing a rifamycin, suspected relapses/treatment failures should be managed with regimens active against rifamycin-resistant TB until susceptibility results from a new isolate become available. For those who have completed treatment and are clinically stable, no further action is necessary, although all patients should be educated about signs and symptoms of relapse.

Please feel free to call Dr. John Bernardo at (617) 983-6970, if you have any questions.

Inside

Epidemiology

Update on Rabies in Humans

In March 2002, a 28-year-old California man died of rabies after a 14-day illness. Bats were identified in his home, but direct exposure through a bite was not reported.

This episode serves as a reminder that bat exposures must be carefully evaluated. Bat bites may go unnoticed and be mistaken for an insect bite or sting. Bats captured following a potential human exposure should never be released, but should be submitted to the State Laboratory Institute for rabies testing. Post-exposure prophylaxis should be given in any situation where a bat is physically present and a bite, or other exposure/contact, cannot be ruled out. If the bat is available and can be tested promptly, post-exposure prophylaxis may be postponed pending test results, which usually take 1-2 days. Contact your local board of health or Massachusetts Department of Public Health for help with assessing rabies exposures and submission of animals.

Rabies in humans continues to be rare in the United States, thanks to the prevention efforts of local public health agents, animal control officers, and health care providers. Still, rabies is an ever-present threat. Since September 1992, when the raccoon strain of rabies first entered Massachusetts, through February 2002, over 3,300 animals have tested positive for raccoon strain rabies, including: 2,065 raccoons, 1,059 skunks, 93 cats, 70 woodchucks, 69 foxes, 12 cattle, 4 dogs, and 19 other farm and wild animals. In addition, 221 bats among 4,018 submitted for testing were positive.

Two statewide campaigns this spring were directed towards rabies prevention. Health educators in the MDPH Division of Epidemiology and Immunization developed rabies awareness materials, which were sent to each of the state's 2,500 elementary schools, as well as to public libraries and local boards of health. The Department of Food and Agriculture, Bureau of Animal Health organized Rabies Vaccination Days. In collaboration with local boards of health, 160 towns participated, sponsoring and promoting low-cost vaccination clinics. Approximately 1,600 dogs, cats, and ferrets received their shots.

As part of the rabies awareness program for schools, MDPH organized a poster contest and received 47 entries from 14 schools. In one of the prize-winning posters, a fourth grader from Fitchburg MA, reminds us:

- Stay away from stray dogs and animals that look strange.
- If bitten, wash the cut and go to the doctor's office.
- Cover trash cans tightly

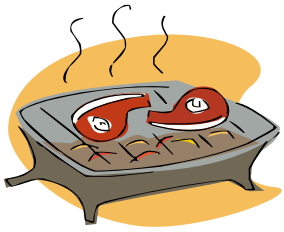
We hope that school children bring this message home to parents across Massachusetts. See www.state.ma.us/dph/cdc/epii/rabies/rabies.htm for links to rabies fact sheets and a fun site for children. If you would like to have a rabies presenta-

Hot off the Grill! Summertime Foodborne Illnesses

Every summer there is an increase in reported foodborne illnesses due to *Salmonella*, *Campylobacter*, and *E. coli* O157:H7. In 2001, 48% of the 1327 cases of Salmonella and 70% of the 117 cases of *E. coli* O157:H7 were reported to the Massachusetts Department of Public Health (MDPH) between June and September. This surge in foodborne illness during the summer is in part due to the increase in outdoor entertaining, when people leave foods out at warm temperatures, for extended periods of time, and transport of foods without proper refrigeration. Good hygiene is also more difficult to maintain in the summer. Not only can foods become contaminated with bacteria and viruses, people who carry infectious agents can spread them to others if they do not wash their hands.

For safe summertime fun and food consumption in order to minimize the risk of foodborne illness, MDPH recommends the following:

- Wash your hands thoroughly with soap and water before eating or preparing food, after using the toilet, and after changing diapers.
- Make sure that uncooked animal-derived food products do not contaminate foods served raw (such as vegetables), during meal preparation or refrigeration.
- Wash fruits and vegetables thoroughly.
- Cook all ground beef, hamburgers, and chicken thoroughly (till no longer pink).
- Use separate plates for raw and cooked barbecue items.
- Keep cold foods cold and hot foods hot. Cold foods should be kept at 45°F; hot foods should be kept at 140°F.
- Use adequate coolers or other containers to maintain food temperature for travel/service.



Results of the 2001 Immunization Assessment

The Massachusetts Immunization Program (MIP) has been conducting immunization assessments in pediatric provider offices and community health centers since 1993. A site visit consists of an assessment of Vaccines for Children (VFC) Program compliance, proper storage and handling of vaccines, and immunization levels of 2-year-olds in the practice.

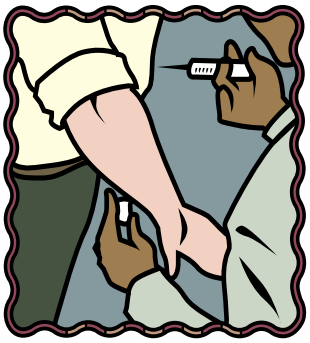
In 2001, the MIP used a lot quality assurance (LQA) methodology, whereby approximately 40 immunization charts were assessed at each site, and a site "passed" or "failed" the assessment based on a predetermined threshold. The LQA methodology enabled the MIP to expand the number of immunization site visits performed each year from 74 in 1999 to 344 in 2001. Each practice received a quality assurance feedback session with an MIP staff member on the day of the assessment. In 2002, the MIP plans to conduct at least 400 immunization assessments. By 2004, the MIP hopes to have assessed every pediatric primary care provider that sees 2-year-old patients in Massachusetts.

The MIP is participating in two initiatives to strengthen quality assurance in pediatric offices. The first is in collaboration with the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) and managed care organizations (MCOs) administered by the state's Medicaid agency, the Division of Medical Assistance (DMA). It is based on a reminder/recall initiative to educate providers about the importance of reminder/recall systems in improving immunization rates. The second initiative is an immunization toolkit, which includes the latest immunization recommendations, schedules and guidelines, vaccine safety information, and "best practices" tools. These toolkits will be distributed to providers during immunization assessments in 2002.

Immunization materials and further information about the MIP's immunization assessment process can be obtained by calling (617) 983-6800 or toll-free (888) 658-2850.

Regional Immunization Offices

Central Regional Office: (508) 792-7880
180 Beaman Street, West Boylston, MA 01583
Boston Regional Office: (617) 983-6860
305 South Street, Jamaica Plain, MA 02130
Metro West Regional Office: (781) 828-7700
5 Randolph Street, Canton, MA 02021
Northeast Regional Office: (978) 851-7261
365 East Street, Tewksbury, MA 01876
Southeast Regional Office: (508) 947-1231
109 Rhode Island Road, Lakeville, MA 02347
Western Regional Office: (413) 545-6600
UMass Amherst, N424, Morrill Bldg, Amherst, MA 01003



Vaccines Cost Money

Massachusetts is one of only ten states that distribute vaccines free of charge to all public and private pediatric providers for the immunization of all children through 18 years of age. Health care providers can help support Massachusetts universal distribution program by storing vaccine properly and accounting for each dose of vaccine ordered.

Proper Vaccine Storage
Vaccines (with the exception of varicella) should be stored between **2°C to 8°C (35°F to 46°F)**. Colder is not better. **Freezing destroys** the antigen (the part of the vaccine that causes immunity to develop) for vaccines other than varicella. In the past year, approximately 8% of provider sites stored vaccine at improper temperatures. Replacement of this vaccine is expensive. A one month supply of vaccine for an average size pediatric provider costs approximately $3,000. To maintain the proper storage temperature for refrigerated vaccines and frozen varicella, **check and record** the refrigerator and freezer **temperatures** on a daily log sheet **at the beginning and end of each workday.**

Vaccine Accountability
Funding for vaccines comes from both the state and federal government. Distributed vaccine that is not accounted for jeopardizes future vaccine purchases. Account for all vaccines administered to each age group on the *Vaccine Usage Report*. If vaccine doses are damaged, lost, or expired, account for these doses on your *Vaccine Order Form*.

New vaccines will become available (including combination vaccines) and the price of existing vaccines will increase. Your commitment to storing vaccines properly and documenting vaccine usage accurately, is a vital part of assuring the successful continuation of the universal vaccine distribution program. If you have questions, please contact your regional MDPH office, or call the MIP's Vaccine Management Unit at (617) 983-6828.

STD

Sexually Transmitted Diseases, 2001

Over the past twelve years (1990 through 2001) there have been dramatic declines in incidence rates of STD in Massachusetts.

Chlamydia rates declined 28% from 204 cases per 100,000 population in 1990 (12,251 cases reported) to 164 cases per 100,000 population in 2001 (10,402 cases reported). However, there is a 3.3% increase over the 10,073 cases reported in 2000. The number of reported cases increased each year since 1996, when the State Laboratory adopted a more sensitive nucleic acid amplification test system called "ligase chain reaction", or LCR. The proportion of positive chlamydia tests among women seen in STD and family planning clinics doubled with application of this new technology. In addition, through the use of additional federal funds, chlamydia screening was expanded to the women seen at Title X family planning clinics, jails, Department of Youth Services lock-up facilities, homeless shelters and HIV drop-in centers. Testing volume has increased from 3,793 tests in 1990 to 21,255 in 2001.

Gonorrhea rates declined 70% from 125 cases per 100,000 population in 1990 (7,531 cases reported) to 51 cases per 100,000 population (3,214 cases reported) in 2001. However, this is a 24 % increase over the number of cases reported in 2000 (2,487 cases reported). The number of reported cases has been increasing since 1997. The increase is mostly among youth in minority communities.

Incidence rates for all stages of syphilis declined 75% from 28 cases per 100,000 population in 1990 to 7 cases per 100,000 population in 2001. This reflects continued efforts to expand syphilis screening in high-risk populations, particularly in all city, state and county correctional facilities in Massachusetts; large scale community education efforts (HIV prevention and syphilis elimination); and changes in drug use pattern in Massachusetts involving a switch from crack cocaine to heroin.

Infectious (early) syphilis declined dramatically from 11.6 cases per 100,000 population in 1990 (1,175 cases reported) to 1.7 cases per 100,000 population in 2001 (110 cases reported). The number of reported cases declined to the lowest level recorded since 1918 (97 cases) in 1999, but rose to 139 reported cases in 2000. Re-emergence of infectious syphilis among men who have sex with men (MSM) is a worrisome trend. In the late 1970's and early 1980's, approximately 50% of the reported infectious syphilis in Massachusetts was among MSM. This declined to less than 1% of cases in the early 1990's. In 2001, 52 of the 110 cases (47%) were diagnosed in MSM.

STD prevention and control depends on maintaining and enhancing screening services to higher risk and under-served groups; expanding collaborations with community-based organizations; and seeking ways to improve infrastructure to manage, analyze and use more diverse sources and types of information to inform and shape prevention programming.

New Initiatives to Gather Behavioral Data

Disease surveillance is a core function of public health. In recent years, there has been a growing recognition for the need to expand traditional case surveillance to surveillance of the behaviors and the determinants of behaviors that lead to infection and disease. Understanding the precursors of elevated risk is critical to the development of effective prevention programs.

The Division of STD Prevention is in the process of altering interview forms so that the relevant questions about risk behaviors will be prompted. These will include questions regarding a history of sexual behaviors, a history of violence, use of condoms, sexual partner preference, exchanges of sex for money and/or drugs, and sites where people seek partners. In parallel, data management systems will be reprogrammed in order to store and process information.

Other aspects of behavioral surveillance are also being put into place. One clinic is collecting information while piloting the use of Stages of Change Theory in order to develop behavioral interventions. STD clinic populations can be characterized according to the stages of behavioral change and then followed for what factors might be significant in moving them along the spectrum of behavior change. Survey questions have been placed on the *Clinic Intake Forms* that ask about history of sexual violence.

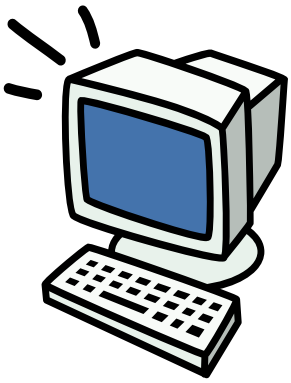
Behavioral surveillance holds promise, yet it is challenging to sustain the resources necessary to collect, analyze, report and act on the data. However, the critical need for the data generated through behavioral surveillance for prevention programs is worth the investment.

Don't Forget.....

Communicable Disease Update is available on the world wide web at:

http://www.state.ma.us/dph/cdc/update/comnews.htm

Look to find our current issue and past issues dating back to July 1996.



You Be The Epi

A report of an isolate of *Neisseria gonorrhoeae* from a rectal swab was received from a laboratory. You contact the physician listed on the laboratory report. The doctor tells you that the patient is a 32-year-old man who complained of pain, burning and discharge from the rectum beginning one week before. The doctor agrees to arrange for a Disease Intervention Specialist (DIS) to meet the man to speak with him about informing partners and to reinforce risk-reducing prevention messages his clinician gave during the clinical encounter. The DIS meets the man, who divulges the names and addresses of ten men with whom he has had sex within the two weeks prior to the onset of symptoms.

Locating and contacting ten partners is a lot of work. What if the contacts have contacts? Is it worth it? Should the DIS try to contact every one of the partners, or would sampling be sufficient? What is gained by trying to interview every partner?

Identifying all susceptible people who are exposed to a particular pathogen is a time-tested public health approach to investigation and disease intervention. Disease intervention for sexually transmitted diseases follows the same model. The fact that the pathogens are transmitted sexually adds a need for increased sensitivity in the process.

Should the DIS try to contact and interview everyone who is named? The investigation does not begin and end with people who are named. There is much more to learn. The interviews will allow the DIS to learn of patterns of the individuals connected with each other. That information may lead to a bar, a public sex area, an Internet chat room, etc. in which additional prevention work can be conducted. If some of the men who are direct contacts met at a particular bar, then there are probably other men who connected with the bar who are also participating in high-risk behaviors. They may have some of the same partners as those who were named. This bar would then be a good place to offer screening, outreach education, to ensure that condoms are available, and/or to place posters and notices informing of the risks of infection. The more people contacted, the greater the likelihood that social networks will be addressed. This will offer additional intervention and prevention possibilities that would not be evident if attention was paid only to direct contacts of people reported with sexually transmitted infections.

New Senior Level Bureau Position Dedicated to Local Public Health

The Bureau of Communicable Disease Control announces the appointment of a new bureau Local Health Director. Paul Etkind, currently Director of the Bureau's Division of STD Prevention, will serve in this capacity, devoting his time to addressing local public health needs related to communicable disease prevention and control. Dr. Etkind has served the Department of Public Health for over 25 years in program management, surveillance and epidemiology positions, including direction of the Epidemiology and Immunization Programs prior to leading the STD Division. We are excited about this new opportunity to strengthen partnerships with local communities.

New HPV Surveillance Project Begins

The Division of STD Prevention is one of six grantees of the federal Centers for Disease Control and Prevention (CDC) for the Sentinel Surveillance Project for Human Papilloma Virus (HPV) Infection Among Women. The Division will be working with the other awardees in Seattle, Los Angeles, Denver, New Orleans, and Baltimore on this three-year project. HPV is one of the most common sexually transmitted diseases. HPV causes genital warts. There are more than 100 types of HPV. Some types of HPV are classified as "high-risk" for their association with genital, particularly cervical, and anal cancer. The goal of this study is to assess the prevalence of high-risk HPV types in women of different ages and risk categories. Clinical sites include STD clinics, HIV care sites, family planning clinics and primary care clinics throughout Massachusetts. Women who are to have a Pap smear are eligible. Cervical samples will be tested by the Digene Hybrid Capture II test to seek evidence of the presence of high-risk HPV types. The results of the study will enhance the understanding of the sexual, racial/ethnic and geographic factors in the epidemiology of high risk HPV, provide better characterization of cervical cytology readings among infected women and should inform the design and evaluation of HPV vaccine trials. Enrollment will begin this summer.

Refugee and Immigrant Health

A Recap of the 4th Conference on Refugee Women's Health

The fourth annual refugee health conference, focusing on refugee women's health, was held on April 3, 2002 at the Massachusetts Medical Society (MMS). The conference was a collaborative effort of the Refugee and Immigrant Health Program, the Massachusetts Office for Refugees and Immigrants, and the MMS. Conference participants included clinical and administrative staff from refugee health assessment sites, community health centers, public health programs, resettlement agencies, and refugee community agencies.

The morning session focused on refugees overseas. Ms. Kelly Gauger with the U.S. Department of State (DOS) provided an update on **refugee admissions**. Although the pace of admissions has been slow following the lifting of the post-September 11 moratorium, the Immigration and Naturalization Service (INS) and DOS are committed to meeting the admissions ceiling of 70,000 refugees by September 30. Additional INS officers are being trained for refugee interviews to increase the numbers to be considered. New security measures are in place, including name clearance and fingerprinting on arrival in the U.S.

Among the Priority Two populations (Groups of Special Concern) for U.S. resettlement are Iranian religious minorities and Cubans. In-country processing programs continue for Vietnamese and members of certain religious groups of the former Soviet Union. The designation is being considered for approximately 10,000 Somali Bantu refugees in Kenya and approximately 1,000 Vietnamese Montagnards in Cambodia. The latter group will mostly resettle in North Carolina. At this time there will not be a Priority Two designation for Afghani women at risk in Pakistan.

Dr. Maria Cano from the Centers for Disease Control and Prevention (CDC) gave an overview of the **overseas medical examination** process for refugees. The examination report forms have been updated, expanded and renamed. The forms now reflect the exam requirements. The Technical Instructions have complete information on the examination and are on the CDC web site at www.cdc.gov/ncidod/dq/technica.htm.

Ms. Margaret Pollack, director of the Office of Population at the DOS, offered **global perspectives on refugee women's health**. Of the approximately 30 million refugees and internally displaced persons, some 80% are women and children. Women refugees face particular physical and mental health vulnerabilities. Among the issues are crowded and unsanitary conditions, poor nutrition and disease, and stress from displacement, separation from family members, and change in social norms. Reproductive health services in refugee settings are now recognized as essential. Program priorities include:

- Safe motherhood – Pregnancy is a serious health threat for refugee women. The maternal mortality rate in Sierra Leone was 1,800 per 100,000 live births, compared with 9.9 in the U.S.
- Sexually transmitted diseases, including HIV/AIDS: Rates of STDs are high in areas of poverty, powerlessness and social instability. In Rwanda, 17% of refugee women who had been raped were HIV positive.
- Voluntary family planning: In refugee situations, family planning services are often rudimentary and refugee women struggle with unwanted, unplanned or poorly spaced pregnancies.
- Sexual and gender based violence: Violence against women is endemic in conflict situations and has profound consequences for refugee women's reproductive health.

In emergency situations, initial services should include preventing and managing the consequences of sexual and gender based violence, reducing HIV transmission, preventing neonatal and maternal morbidity and mortality, and planning for the provision of reproductive health services integrated into public health services.

Fourteen area professionals* from a wide variety of backgrounds formed the panels in four breakout sessions that focused on resettled refugee women and girls. Selected highlights from these sessions are summarized here.

Meeting the Health Care Needs of Refugee Women was the focus of the first workshop. Issues were divided into four categories: (1) those not related to country conditions; (2) those related to country conditions; (3) those related to country conditions and made worse by uprooting and torture; and (4) those related to torture and ill treatment. Among the challenges to care-providers are a lack of knowledge of and sensitivity to the experiences of refugee women, language barriers, cultural beliefs and customs, psychiatric disease, access to services, and expectations. Quality medical care for refugee women requires a trusting provider-patient relationship and elicitation of a complete history of trauma experiences.

Female Circumcision (FC) / Female Genital Mutilation (FGM) constitutes all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons. The practice occurs mainly in Africa, parts of the Arab world, and parts of Southeast Asia. WHO estimates that in Africa over 130 million girls and women have undergone FGM. This workshop provided information for health care providers related to the health needs of women with FGM as well as the perspective of refugee and immigrant women on how to educate others and eradicate the practice.

Adolescent Refugee Girls and Young Women often have unique needs. Presenters discussed challenges that refugee

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A New Medical Consultant for the TB Division

It is our pleasure to take this opportunity to introduce Dr. John Bernardo as Medical Consultant to the Department's Division of TB Prevention and Control Division, and TB Control Officer for Massachusetts. Dr. Bernardo has long had an interest in tuberculosis. He has managed tuberculosis cases for more than 20 years as a clinician and as Medical Director for the Boston City Hospital/Boston Medical Center TB Clinic, and more recently, as Medical Director and TB Control Officer for the Boston Tuberculosis Program. Dr. Bernardo is active in the National TB Controllers' Association and is a principal investigator for the Centers for Disease Control and Prevention's TB Trials Consortium Boston site at Boston University Medical Center. His basic interests in phagocyte biology are supported by National Institutes of Health, and he manages an active research laboratory at Boston University School of Medicine, where he is Professor of Medicine and Biochemistry.

Dr Bernardo's priorities remain essentially unchanged from those of his predecessor, Dr. Edward Nardell:

1.) Early case finding, with rapid diagnosis and initiation of appropriate therapy for tuberculosis disease.
2.) Timely reporting of all cases and suspects to the Division.
3.) Completion of appropriate treatment for persons with active disease.
4.) Identification of persons at risk for TB infection, with appropriate testing and treatment of latent infection in high-risk persons, including infected contacts of active cases.
5.) Education of health providers about TB and related diseases.
6.) Public education about TB and related health issues in the community.
7.) Clinical consultation to health care providers and organizations.

Dr Bernardo also hopes to introduce new clinical research initiatives to the Division as an extension of his present activities. He can be reached through the Division, (617) 983-6970) or at the Pulmonary Center at Boston University School of Medicine (617) 638-4860. He is also available by email at *jbernardo@lung.bumc.bu.edu*.

Tuberculosis Surveillance Area Reorganization

Nancy Taylor-Flynn, Tuberculosis Surveillance Area (TSA) nurse with the Division of Tuberculosis Prevention and Control (Northeastern MA region), has retired after thirty-four years of state service. To accommodate this change, the Division has reorganized its TSA structure and re-assigned personnel to different regions.

TSA 1 currently covers Central and Western Massachusetts. The TSA 1 office is located in the Department of Public Health's (DPH) Western Regional Health office (RHO) in Northampton. TSA 2 covers Metro Boston, including Suffolk County (excluding Boston), the majority of Middlesex county (extending west to Framingham), and the Western portion of Norfolk County (extending east to Dedham/Westwood). The TSA 2 office is located at the DPH Metro West RHO in Canton. TSA 3 covers the Northeast, with staff located at the DPH Northeast RHO in Tewksbury. TSA 4 covers the City of Boston. TSA 5 covers the Southeastern part of the state, including the Cape and the Islands of Nantucket and Martha's Vineyard. The TSA 5 office is located in the DPH Southeast RHO in Lakeville.

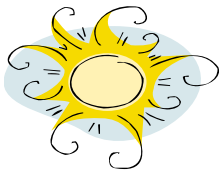
Regional Based Resources:
TSA 1 – Central and Western: (800) 445-1255, ext. 1161; Carol Cahill, RN; Admin. Asst.: Evelyn Thomas

TSA 2 – Metro Boston: (781) 828-7031
Carolyn Harris, RN; Admin. Asst.: Debra Thimas

TSA 3 – Northeast: (978) 851-7261, ext. 4048
Jo-Ann Keegan, RN; Admin. Asst.: Mary Mahoney

TSA 4 – Boston: (617) 534-4585
Boston Public Health Commission TB Program

TSA 5 – Southeast, Cape & Islands:(508) 947-1231, ext. 5139; Joan Thompson-Allen, RN; Admin. Asst.: Kelley Letendre



Refugee Women's Health continued from page six
girls face, particularly as they relate to culture shock and being transplanted to American schools and neighborhoods. Issues related to the mental health and well being of refugee adolescents were explored.

Violence against Refugee and Immigrant Women was addressed in the fourth workshop. After defining violence against refugee and immigrant women, presenters explored its implications and health consequences. Tools and strategies offered to providers focused on recognizing the signs of violence, interviewing and assessment, interventions, risk assessment, confidentiality and safety planning.

*Presenter information and the conference bibliography on refugee women's health are posted on the DPH website www.state.ma.us/dph/cdc/bcdc.htm.

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Save The Dates

Satellite Broadcast Presentations 2002

LIVE satellite broadcasts produced by the National Immunization Program, Centers for Disease Control and Prevention. All programs will be shown in the State Laboratory Auditorium. In addition, the MIP will provide viewing sites, at community colleges — when available — throughout the Commonwealth, check our web site @ http://www.state.ma.us/dph/cdc/epii/imm/events/2002ImmSatelliteCourses.htm

The satellite program broadcasts that are scheduled to date are:

The Immunization Encounter: Critical Issues- June 27, 2002*, Noon to 2:30 PM EST

Immunization Update 2002 - August 15, 2002*, 9:00 to 11:30 AM & Noon to 2:30 PM

Surveillance of Vaccine-Preventable Diseases - December 5, 2002*, Noon to 3:30 PM

All registration, by participants and course evaluation/testing or CME hours or Nursing CEU certificates will be done on-Line either by going to: http://www.phppo.cdc.gov/phtnonline/ or through: http://www.cdc.gov/nip/ed/#Calendar. Always check: http://www.state.ma.us/dph/cdc/epii/imm/events/2002ImmSatelliteCourses.htm for the latest updates on statewide viewing sites.

Also, you can contact Walt Lasota at (617) 983-6834, or through email at: Walter.Lasota@state.ma.us

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